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CLINICS.

Clinical Lecture on Midwifery. By J. Y. Simpson, M. D., Professor of Midwifery in the University of Edinburgh. (Continued from p. 28.)

One more point remains for our consideration. Granting that it is proper to seize a knee, I think it a matter of the very first moment to know

Which knee should be seized?—On this point you will find no directions in any of our modern obstetric works, British or foreign, as far as I know them; and yet I believe the secret of turning with facility and safety in such a case as Anderson's—with the waters evacuated and the uterus contracted—depends upon the knowledge of which of the two lower extremities of the infant should be seized. If we turn with one of the extremities—and whether the foot or the knee—it should be the foot or knee of the limb on the *opposite side of the body* to that which is presenting. Thus, if the right shoulder or arm presents, we should take hold of the left knee or foot; and if the left arm or shoulder presents, we should take hold of the right knee or foot. I repeat, that I believe this point to be one of the most essential importance: and the reasons for the rule are simple.

In bringing down the fœtus in the operation of turning, we may, and should, produce, two kinds of alteration in its position and figure. Thus, we may bend or flex the body forwards upon the *transverse* axis of the trunk; and we may rotate or turn the body round upon the *longitudinal* axis of the trunk. If we merely flex it, the operation of version will be one of difficulty; if we both flex and rotate the trunk at the same time, the operation will be one of comparative facility. By merely flexing the body upon its transverse axis, we are liable to bring down one of the lower extremities, whilst we do not displace the upper extremity, which is primarily presenting at the os uteri. If we *both* rotate and flex the body—that is, turn it both on its transverse and longitudinal axes—at the same moment, whilst we bring down the pelvic extremity of the child, the turning of the body of the infant carries away from the os uteri the part originally presenting.

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Many of you must be acquainted with the fact, that obstetric authors have proposed various methods of removing away from the cervix uteri the presenting arm or shoulder, in order to allow of more space for the part which is brought down, and to produce the necessary evolution of the child. Thus some recommend the presenting part to be pushed up before we seize the feet; others advise the foot to be seized with the one hand, and the presenting part to be pushed up with the other; and others again counsel us to bring down one or both feet, secure them with a tape (as you see in the plate of Moreau), and, whilst pulling with this tape, to introduce the hand, after the lower extremities are brought down, for the purpose of pushing up the presenting portion of the upper extremity.

All these rules and complications are at once avoided by following the principles that I have just stated to you, of bringing down, whenever it is possible, the knee opposite that of the presenting arm or shoulder. When we do this, by carrying the knee diagonally across, if I may so speak, the abdomen of the child to the os uteri, we both, as I have said, *flex and rotate* at the same time the trunk of the infant, and in doing so, the semi-rotation of the trunk inevitably carries up the presenting arm, in proportion as the knee which is laid hold of is pulled down by the operator. I would add this, as another of the advantages of turning with one extremity, for if we pulled down both knees or both feet, or the foot or knee which was nearest to us, we would produce in many instances mere flexion of the body, *without* that rotation of it which is necessary to carry up and out of the os uteri, the presenting part of the infant.

I have insisted upon the advantages of taking hold of the knee that is highest and furthest from you, and believe this to be a matter of the very first moment. Now, it may appear to some of you that it would be more difficult to seize this knee than the knee of the side corresponding to the presenting arm; but if you reflect for a moment you will see that this difficulty is more imaginary than real. Both knees of the child, as the infant lies folded up in utero, are generally in juxta-position, and lying upon the abdomen of the infant, near the umbilicus. If, therefore, in passing your hand into the uterus, you insinuate it as you ought to do, along the anterior surface of the thorax and abdomen of the child, you come in contact with both knees at the same time. And the rule which I would give you is this, that instead of hooking your finger, or fingers, into the flexure of the lower or nearer knee, you hook them instead into the flexure of the upper, more distant, or opposite one. Both are so far, in general, equally near, or equally distant, and you seize the one or the other according as you take care to turn your finger so as to hook it into the flexure of the lower or the flexure of the upper. It has been strongly objected by some authors to the mode of turning by the knee or knees, that we cannot with the hand in utero make a sufficient

Diagnosis between the knee and the elbow.—It is averred that the operator is exceedingly liable to mistake the elbow of the child for the knee, and thus to bring down the opposite arm instead of lower extremity—a result that would certainly render the case only the more complicated. I believe, however, that we might be and are equally liable to confound the foot with the hand, and thus lead to the same consequence, while the following simple rule will always enable you to escape the error and danger of mistaking an elbow for a knee. Suppose the child to be lying, as it does, with its extremities doubled up in the uterus, the elbow and knee may be always distinguished from each other by the *opposite directions* in which they point.—You have the salient angle, convexity, or rotundity of the knee, always looking upwards towards the upper or cephalic extremity of the child, whereas you have the salient angle, convexity, or rotundity of the elbow, always looking towards the lower or pelvic extremity of the infant. Hence, if we know the position in which the infant is lying, (and this we always do, for other reasons, ascertain previous to commencing our operation,) we may, by attending to this single fact, easily distinguish in all cases a knee from an elbow.

There is one point worthy of every attention in regard to the operation we have been considering, which I have not yet alluded to. It is this, that—particularly in cases of difficulty—you require to

Use both your hands for the operation of turning.—In making this observation, I mean that whilst we have one hand *internally* in the uterus, we derive the greatest possible aid, in most cases, from manipulating the uterus and infant with the other hand

placed *externally* on the surface of the abdomen. Each hand thus assists the other to a degree which it would not be easy to appreciate, except you yourselves were actually performing the operation. It would be extremely difficult, if not impossible, in some cases, to effect the operation with the single introduced hand; and in all cases it greatly aids and facilitates the operation. The external hand fixes the uterus and fœtus during the introduction of the internal one;—it holds the fœtus *in situ*, while we attempt to seize the necessary limb or limbs, or it assists in moving those parts, when required, towards the introduced hand;—and it often aids us vastly in promoting the version or evolution of the body of the child, after we have seized the part which we search for. Indeed, this power of assisting one hand with the other, in the different steps of the operation of turning, forms the principal reason for introducing, as I have sometimes done, the left as the operating hand into the uterus—for thus we can, by passing the right hand between the thighs, and over the abdominal surface of the uterus, (the woman lying on her left side,) have more perfect control over the child by our external manipulations with the latter hand. Besides, the left hand, when the patient is in the position I have described, more readily adapts itself to the configuration and axes of the pelvis. If we introduce and turn with the right hand, it is more awkward and difficult to manipulate the abdominal surface of the uterus with the left.

The mode of turning which I have recommended to you was followed in the case of Anderson. When I was first called to see her, all things were in a condition suitable for undertaking the operation. The membranes had burst some hours previously, when the os uteri was still comparatively rigid. It is, no doubt, a matter of moment to be able to turn *before* the waters have escaped, because, as I have already stated to you, the operation is then greatly more simple; but when the membranes do break —as in the case before us—with the os uteri still undilated and undilatable, we must wait with patience, and employ such measures as tend to relax that part. In the present instance, blood-letting was had recourse to for this purpose, and antimony exhibited. A short time before I saw her, Dr. Barry had very properly given her a large dose of opium, in order to moderate the spasmodic or clonic contractions of the uterus, so as to admit of the more easy performance of the version of the child. The os uteri was quite dilatable when I reached the hospital, but the tonic contraction of the organ was so great that I feared there might be some delay and difficulty in the introduction of the hand, and evolution of the child. Such, however, was not the case to the degree anticipated, and the version was accomplished in two or three minutes.

The child was lying with its head towards the right iliac fossa, and its pelvis towards the left. The face, abdomen, and extremities of the infant were looking forwards. I, therefore, as we always do in such cases, passed up my hand between the anterior or pubic surface of the uterus and the infant, in order to reach more easily the knee which I wished to seize.

As to the place, or side, where we ought to pass our hand—that is whether between the infant and the pubis, or between the infant and the sacrum—the rule is simple and evident. We pass our hand, as in the case before us, between the pubis and the infant, when we know the extremities of the child are looking anteriorly. We pass our hand between the sacrum and the infant, in those other cases in which we know the limbs of the child to look posteriorly. We do so for two reasons,—*first*, because there is always the greatest space for the introduction of the hand on that side of the fœtus to which its face, abdomen, and angulated extremities, look; and, *secondly*, it is only, of course, on this side of the fœtus that we can find and secure the lower extremities in order to produce the required evolution and extraction. Dr. Lee lays it down as one of his "two most important rules" in turning, that,—however the trunk and extremities of the child may be situated—that is, whether the extremities look anteriorly or posteriorly—you ought "to pass up the hand between the *anterior* and shallow part of the pelvis, and the presenting part of the child." If the back of the infant were turned, as it sometimes is, to this "anterior or shallow part," it would be impossible, by any search in that situation, to get hold of one or other of the legs of the child, which are situated in the very opposite part of the uterus, and on the opposite side of the body of the fœtus; —and if the feet were thus really seized, they would be brought over the back of the child, and the spine so far greatly endan-

gered. But Dr. Lee's rule is so very obviously erroneous, and the result of some misconception or disregard of the mechanism of transverse presentation and turning, as not to require any formal refutation. His second important rule, "that when one hand is rendered powerless by the pressure of the uterus, you ought to withdraw this hand, and replace it by the other," will doubtless be in many cases, I fear, an unavoidable result of the mismanagement advocated by the first—and is rarely, if ever, required when you employ the proper hand at once. And every new and unnecessary introduction of the hand must be reprobated, as inflicting a new and additional source of danger upon the patient,—and hence should be avoided as far as possible.

You saw, in this instance, what are the usual preliminary measures adopted in connection with the operation of turning. We kept, as I showed you at the time, the patient placed upon her left side, with the trunk of her body situated across the bed. The right knee was raised by the hand of an assistant, and the uterus kept fixed and steady by pressure on the external surface of the abdomen. In preparing the hand and forearm for the operation of turning, these parts were perfectly uncovered, and everywhere anointed with lard, with the exception of the palmar aspect of the hand and fingers. These latter parts require always to be kept free, in order to secure a proper hold of the presenting part.

After cautiously passing the hand into the uterus, along the anterior surface of the protruded arm, I glided it between the anterior surface of the thorax of the child, and the anterior wall of the uterus, laying it flat during one slight pain that supervened, and insinuating it onwards immediately afterwards, till I reached the two knees lying in the umbilical region of the infant. I passed one finger into the flexure of the upper knee, and thus got sufficiently firm hold of that part, without displacing the lower extremities to any extent. Assuring myself, as we always do in the process of version of the child, of the *complete absence* of all clonic contraction of the uterus, I easily turned it round with the purchase I had, and brought down the left lower extremity, the infant making a complete rotation during its evolution, as we shall see immediately from the direction of the toes, abdomen, and face.

We thus, you observe, make the version or evolution of the child during the *absence* of any uterine pain, but after bringing down the extremity, should any further assistance be required towards the extraction of the child,—it must, I beg you especially to remark, be made not during the absence of uterine contractions, but during the *presence* of them. In most cases, indeed, after the version is performed. we allow the uterine contractions themselves to expel the infant, but it was not necessary to wait in such a case as Anderson's, the pains being trifling, and the child being dead. I therefore pulled gently at the protruding leg during each subsequent contraction, and ultimately extracted the head from the pelvis by a purchase obtained by passing the two fingers of the right hand over the neck of the child, and introducing the other two into its mouth. —*Lond. and Ed. Month. Journ.*, Feb., 1845.

[To be continued.]

SKETCHES AND ILLUSTRATIONS OF MEDICAL DELUSIONS.

Quackery.—The bold assumptions and cunning devices of imposture have always succeeded in securing, as its dupes and supporters, a large class in society—but never perhaps to a greater extent than at the present period. The boldest empiricism pervades now almost every pursuit in life, and nearly every department of human knowledge. With all our boasted advance in moral and intellectual improvement, it has been permitted to usurp the temple of religion, the hall of science, and the field of literature. Deluded by its pretended regard for human rights and freedom of opinion, man has refused to bow the head or to bend the knee to any power on earth, or, we had almost added, in heaven either—and, at the same time, he has closed his mind and heart against the influence of every species of authority, whether exercised for good or for evil. Subjects the most sublime and intricate—questions of the greatest moment in reference to his present and future welfare —are approached with the utmost indifference, and discussed with the same familiarity and flippancy as those of the most familiar and trivial character. All would now enter by force into the temple of science, cast forth its true votaries, and rifle with profane hands its treasures. The long and tedious roads to knowledge, pursued by our forefathers, are deserted—and every thing that requires time and labour for its acquisition is de-

nounced as contributing nothing to the immediate good of the community. All that concerns the human race, whether mentally, morally or physically, is attempted to be reduced to one level by the miserable test of a false utilitarianism; and in a professed opposition to the fictitious distinctions of society, the reverence which is due to superior virtue, talents, knowledge and skill, has become almost entirely extinct.—*Condie's Annual Address before the Philad. Med. Soc.*

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Medical Graduates in 1845.—University of Pennsylvania, 164; Medical College of the State of South Carolina, 74; Medical College of Georgia, 33; Geneva Medical College, 41; St. Louis University, 14; Pennsylvania College, 14.

Maine Insane Hospital.—Dr. James Bates has been chosen Superintendent of this institution.

State Lunatic Asylum, Worcester.—Dr. Rufus Woodward, a son of the distinguished superintendent of this institution, has been appointed Assistant Physician.

Columbia College, D. C.—Dr. Harvey Lindsley has been elected Professor of the Practice of Medicine in this school, vacant by the death of Dr. Sewall.

Obituary Record.—It is with regret that we have to record the death of Dr. Thomas Sewall, of Washington, Professor of the Practice of Medicine in Columbia College, a gentleman of extensive practice and reputation, and very highly and justly esteemed.

Died, at Hudson, N. Y., Feb. 10, 1845, Samuel White, M. D., aged 68 years, Principal of the Hudson Lunatic Asylum, and a distinguished surgeon.

FOREIGN INTELLIGENCE.

Liquefaction and Solidification of the Gases.—Our readers are probably aware of the recent very interesting experiments of Mr. Faraday relative to the liquefaction and solidification of the gases, a notice of which was given in the number of the *American Journal of the Medical Sciences* for last month.

The following are his latest results, as communicated to M. Dumas, and published in the *Annales de Chimie* for January last.

Olefiant gas condenses into a fine, clear, colourless, transparent liquid, but it does not solidify; it dissolves the resinous bituminous oily bodies.

Pure hydriodic acid may be obtained in either the solid or liquid state. Solid hydriodic acid is very clear, colourless, and transparent, generally presenting a few fissures, which traverse the mass; it greatly resembles ice.

Hydrobromic acid may also be obtained either as a limpid and colourless liquor, or as a clear and transparent solid body.

These two acids require very careful distillation, in close vessels and under high pressure, to be obtained pure and colourless.

Fluosilicic acid has been condensed to the liquid state, but it is necessary to operate at the lowest temperature. It is extremely liquid, and as mobile as hot ether. It then produces a pressure of about nine atmospheres, and does not give any sign of solidification. It is transparent and colourless.

Fluoboric acid and phosphuretted hydrogen presented some results of condensation.

Hydrochloric acid liquefies readily, at least at the pressure of one atmosphere, but it does not solidify.

Sulphurous acid congeals immediately, as might be expected.

Sulphuretted hydrogen becomes solid, and then constitutes a white, crystalline, transparent mass, rather resembling congealed nitrate of ammonia or camphor than frozen water.

Carbonic acid, when it thus passes from the liquid to the solid state, without being dispersed in the fall of snow, constitutes a very beautiful substance, as transparent as crystal, so that I doubted for a few minutes whether the tube which contained it was full in vacuô, and I was even obliged to fuse a portion of it in order to ascertain the presence of a solid body. Solid carbonic acid exerts a pressure of six atmospheres, which prove to me how easily liquid carbonic acid should become solid when it is *laché* in the open air.

Oxide of chlorine is a fine, very friable, orange-red crystalline substance; it does not present any indication of explosive power.

Protoxide of nitrogen constitutes, when solidified, a fine transparent or colourless crystalline body; but in this state its vapour

is not equivalent to the pressure of one atmosphere; and this result agrees with another experiment, in which, having opened a vessel containing this liquid, part of it evaporated and cooled the remainder, but did not solidify it. The cold produced by this evaporation is very great, which was proved by putting the tube and its contents into a bath of solid carbonic acid and ether in the air. This bath, which instantly freezes mercury, acted as if it had been a vessel filled with a hot liquid, and immediately caused the protoxide of nitrogen to boil violently. From this I am disposed to employ liquid protoxide of nitrogen for new experiments on hydrogen, oxygen and nitrogen; for, by placing a bath of this liquid protoxide in a pneumatic machine, and by expelling the air and gas, we may place the bath of protoxide relative to that of carbonic acid in the vacuum, in the same ratio as these two baths observed in the air.

Cyanogen congeals, as Bussy has already observed.

Perfectly pure and dry ammonia may be obtained as a solid, white, crystalline and transparent substance, heavier than liquid ammonia, and having very little odour, on account of the feeble tension of its vapour at this temperature.

Arseniuretted hydrogen and chlorine do not pass from the liquid to the solid state.

Alcohol becomes as thick as cold oil, but does not crystallize any more than caoutchouc, camphine and oil of turpentine; but these bodies become viscid.

Binoxide of nitrogen and oxide of carbon gave no sign of liquefaction at the lowest temperature, and at a pressure of from thirty to thirty-five atmospheres.

In making these general observations, I have determined many numbers relative to the point of fusion of these various gases, to their tension at different temperatures, &c. The numbers will be given in the memoir which I am preparing on this subject, and in which I hope to have something new to say concerning the state which oxygen, nitrogen and hydrogen assume in passing to the liquid state. Will this last body be developed in the metallic form, as you think? Will nitrogen be a metal, or will it retain its place among the non-metallic bodies? This will be decided by experiment.

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On Toothache. By Dr. Heiden, of Vienna.—The appellation, toothache, is given to those pains which attack the teeth, or the structures with which they are connected. It may depend either upon congestion, inflammation, or a lesion of innervation. 1°. *Congestion: this may have its seat either in the membrane exterior to the fang of the tooth, in that lining its central canal, or in the ganglion, which supplies the tooth with nerves.* Congestion, when seated in the lining membrane of the fang, may be known by lancinating, throbbing pains, which are increased by any excitement of the system: these pains are variable in their character, sometimes lasting but for a few minutes, and again for as many hours; they are generally increased towards evening, and when the patient is in bed. The tooth, whose lining membrane is affected, is sensitive to the touch, or to pressure, and frequently conveys the sensation of being somewhat above the level of the surrounding teeth. The frequent application of cold water to the affected tooth is one of the best means of cure that can be adopted in this form of odontalgia. 2°. *Congestion in the lining membrane of the central canal, and of the dental nerves.*—Toothache dependent upon these causes, may be distinguished from the variety just described, by the tooth not being painful on pressure, nor conveying the sensation of prominency over its fellows. It may be also distinguished by the effect which cold water produces upon it; if the tooth be carious at the crown, cold water immediately gives relief, but if it be not so, the pain undergoes an exacerbation for some time, but under the use of the remedy it eventually disappears. Young, plethoric persons, and pregnant women, are those most subject to this form of toothache. In obstinate cases, besides the local application of cold water, it may be necessary to use the foot-bath, and administer purgatives. Where caries of the tooth exists along with this form of congestion, timely plugging must be had recourse to. All stimulants, such as the tinctures in common use for curing toothache, must be avoided here, as they only increase the mischief. *Inflammation.*—This process, when occurring in the teeth of a healthy individual, will produce the phenomena of healthy inflammation in any other part of the body; in individuals affected with gout, rheumatism, or scrofula, it will present the specific character of these diseases. Inflammation of the internal lining membrane of the tooth-fang (peri-odontitis) oc-

curs much oftener in carious than in healthy teeth; it is characterized by a dull aching rather than actual pain, from which the patient fancies he obtains relief by pressing his teeth strongly together. This dull aching after some time is changed into an acute, *boring* pain, which extends to the neighbouring teeth; at this stage, the affected tooth seems more elevated than its fellows: and this sensation prevents perfect closure of the mouth, and to a great degree interferes with mastication. In some cases this local inflammation causes severe constitutional disturbance, heat and redness of the cheeks, severe headache and general febrile irritation. In this state, if nothing be done to check the local inflammation, this acquires greater intensity. The acute boring pain is now changed into a dull aching, attended with throbbing; if the gum about the affected tooth be examined, it will be found intensely inflamed, the tooth itself is *now* visibly longer than the surrounding ones, and loose; pressure makes the patient feel as if it were about to start from its socket. All these are evidences of suppuration at the root of the tooth, and if it be now extracted, a drop of matter will be seen attached to its root. In cases of intense inflammation of the tooth-fang, the process of inflammation may not be terminated by the formation of matter: inflammation proceeds outwardly to the gum, the alveolus is absorbed, and a portion of the matter formed at the base of the tooth is thus evacuated, when the opening in the gum closes for a short time, until the matter again accumulates. Thus a sort of fistula is formed which can only be healed by the extraction of the tooth. The mischief may not be confined to the root of the tooth alone—which becomes absorbed at its extreme point and roughened,—but may also extend to the jaw-bone and render it carious. It sometimes happens that the cyst containing the pus at the root of the tooth, becomes changed into a mass of pappy consistence, which comes away with the tooth on the latter being extracted. The treatment of this variety of odontalgia must be strictly antiphlogistic. Should the local application of cold fail in completely removing all the symptoms, leeches must be at once, and freely applied to the gums. Where suppuration seems inevitable, a gently diaphoretic treatment, with fomentations of warm water, or warm decoction of poppies, or marsh-mallow, or a solution of extract of henbane, in the proportion of five or ten grains to four ounces of warm water, will be found to assist materially the maturation of the abscess; as soon as the pus has been evacuated, the diseased tooth must be extracted. It very often happens that a great number of the teeth are loosened, without any mechanical cause; this may depend either upon a sub-inflammatory affection of the lining membrane of the alveolar process, or upon that form of cynanche denominated "Parotidœa." In the latter instance, time alone will effect a cure; the former requires for its cure repeated application of leeches over the affected portions of the alveolar process.—*Med. Times*, from *Weiner's Zeitschrift.*

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Delivery in an unconscious state during a sleep of three days.—Dr. SHULTZE was called on the 25th of May, 1843, to the wife of a joiner, who had been pregnant for the fourth time, and who was now in the ninth month of her pregnancy. She had fallen into such a deep sleep, that she could not be awakened by shaking, dragging, nor by stimulants, such as spirit of hartshorn, ether, &c. On the third day of this unnatural sleep, she was unconsciously delivered of a living healthy boy. When the author visited her on the fourth day, she had awoke just a short time before, unaware of having been confined, and perfectly astonished at the occurrence.—*Med. Times*, March 8, 1845, from *Pr. Ver. Zeitung.*

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Urachus not closed after birth.—A child, of one year, had an opening in the navel, out of which urine streamed whenever the child cried. The opening had the form of the orifice of the urethra, the navel was thickened and protruding, and resembled the glans penis. As long as the child remained quiet, the urine ran from the urethra, but whenever the abdomen was pressed or distended, the urine streamed from the opening at the navel. The child, otherwise, is perfectly well.—*Ibid.*, from *Casper's Wochenschrift.*

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Forcible removal of the Uterus and a portion of the large Intestines in a Parturient woman.—An ignorant practitioner of midwifery, in England, has been indicted for manslaughter for having forcibly removed the uterus, and a portion of the large intestines, from a woman whom he had delivered.

It appears from the evidence given at the inquest, that the uterus, with all its appendages, and all the large intestines, except thirteen inches, had been removed. These parts were taken away about two hours after the birth of the child, the practitioner supposing that he was removing the afterbirth.—*Prov. Med. and Surg. Journ.*, March 12, 1845.

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Extraordinary facts relating to Combustion.—At a meeting of the French Academy of Sciences, Feb. 3, M. DUMAS related some experiments to which he had submitted liquid chlorine refrigerated to 90 degrees below the freezing point, in a mixture of solid carbonic acid and ether.

1. Phosphorus falling into liquid chlorine is ignited with a violent explosion.

2. Phosphorus, itself previously cooled in the freezing bath, inflames in the same manner, with violent explosion.

3. Arsenic, taken at the ordinary temperature, is kindled when dropped into liquid chlorine.

4. Antimony, on the contrary, manifests no action on liquid chlorine.

M. BOUSSINGAULT proposed that the Academy should give facilities for extending these experiments (which are attended with much danger) on some determinate plan.—*Lancet*, March 15th.

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Development of Bone.—The following three propositions embody the chief results of M. FLOUREN'S recent investigations upon this most interesting subject of inquiry.

1. *Bone is formed by the periosteum.* 2. *It grows by the super-position of external layers.* 3. *The medullary canal is enlarged by the absorption of the internal layers of the bone.*

The experiments, on which the first of these propositions is based, were performed on dogs. A portion of one of the ribs was excised; removing only the bone, and leaving the periosteum behind. It was found that, after the expiration of a few days, a minute osseous nucleus was formed within the periosteum between the two divided ends of the rib. This nucleus became larger and larger, until at length it rejoined these ends, the one to the other, thus filling up the void space between them.

The numerous preparations, exhibited by M. Flourens at the Royal Academy, clearly show that the new bone is formed in the periosteum; that, when it is first formed, it is completely insulated and apart from the old bone; and that it is only by its gradual development and extension that it ultimately reaches the two divided ends of the old bone, thus re-uniting them together.

The *second* proposition—*bone grows in size by the super-position of external layers*—was established by numerous experiments on dogs and rabbits. One of the tibiæ was exposed, the periosteum divided, and a ring of platinum wire was then passed around between the bone and its investing membrane. The wound being then closed and left undisturbed, it was found after a certain period that the new bone, that had been formed, fairly invested with its recently-deposited layers the platinum wire. The *third* proposition was equally satisfactorily made out by the preparations that were exhibited.—*Med. Chirurg. Rev.*, April, 1845, from *Comptes Rendus.*

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Mortality in Prisons.—Dr. BALY in a paper on this subject, read before the Royal Medical and Chirurgical Society, states that the annual rate of mortality in the English Prisons, exclusive of deaths from Asiatic cholera, has ranged from $15\frac{3}{4}$ per 1000 to nearly 39 per 1000. In France the mortality including deaths from Asiatic cholera, has ranged in the hulks from $39\frac{1}{2}$ to $55\frac{1}{2}$ per 1000; and in the Maisons de Force et de Correction, from $30\frac{1}{2}$ to nearly 87 per 1000. Dr. Baly maintains that the high rate of mortality which prisoners suffer is the effect of their punishment, and is not owing to the unhealthfulness of the class whence criminals are, for the most part, derived.

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Obituary Record.—Died, at London, March 13th, Prof. DANIELL, of King's College, in the 55th year of his age. Whilst attending a meeting of the council of the Royal Society, he was suddenly attacked with apoplexy, and died in less than five minutes from the first seizure.

—— at Paris, on the 11th of March, OLLIVIER D'Angers, aged 49 years, a member of the Royal Academy of Medicine, and of the council of health; and the principal editor of the Annales d'Hygiene Publique et de Médecine Legale.

—— at Paris, on the 21st Feb., at the advanced age of nearly 80 years, M. RIBES, ex-surgeon of the Hôtel des Invalides, and one of the oldest surgeons of the Imperial Army.